

Termination of pregnancy: Perspectives of female students in Durban, South Africa

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Abstract

Pregnancy termination among young women constitutes a public health problem particularly in South Africa where high prevalence of abortion has been recently recorded. The primary objective of this study was to assess the social context in which decisions about termination of pregnancy are taken. In particular, it examines the perspectives of young women with regard to abortion and abortion methods, specifically medical abortion. The study draws on in-depth interviews with female students at a university in Durban, KwaZulu-Natal. The findings suggest that for the majority of women, abortion is a context-driven choice. While women were opposed to abortion for themselves, it was seen as justifiable under certain circumstances. There was a feeling that abortion services should be made accessible to all women that seek them, including medical abortion. The major identified barriers to accessing abortion services were: stigma and cultural beliefs; finances; and negative attitudes of health providers. Termination of pregnancy services should take into account the context in which women make decisions on abortion as well as the barriers women face in accessing abortion services in order to reduce its prevalence.

Keywords: Pregnancy termination; in depth interviews; public health; KwaZulu-Natal

Résumé

L'arrêt de grossesse parmi de jeunes femmes constitue un problème de santé publique en particulier en Afrique du Sud où la forte présence de l'avortement a été récemment enregistrée. Le premier objectif de cette étude était d'évaluer le contexte social dans lequel des décisions au sujet de l'arrêt de la grossesse sont prises. En particulier, il examine les perspectives de jeunes femmes en ce qui concerne l'avortement et les méthodes d'avortement, avortement spécifiquement médical. L'étude dessine sur des entrevues détaillées avec les étudiants féminins à une université à Durban, KwaZulu-Natal. Les résultats suggèrent que pour la majorité de femmes, l'avortement soit un choix contexte-conduit. Tandis que des femmes étaient opposées à l'avortement pour elles-mêmes, on l'a vu en tant que certaines circonstances de dessous justifiables. Il y avait un sentiment que des services d'avortement devraient être rendus accessibles à toutes les femmes qui les cherchent, y compris l'avortement médical. Les barrières identifiées principales aux services de accès d'avortement étaient : stigmatisation et croyance culturelle ; finances ; et attitudes négatives des fournisseurs de santé. L'arrêt des services de grossesse devrait tenir compte du contexte dans lequel les femmes prennent des décisions sur l'avortement comme le visage de femmes de barrières dans des services de accès d'avortement afin de réduire sa prédominance.

Mots-clés: Arrêt de grossesse; entrevues détaillées; santé publique; KwaZulu-Natale

Introduction

Abortion remains one of the most controversial sexual health issues, and yet despite the long-standing stigmas and opposition to its practice; termination of pregnancy remains a common experience for some women around the world. There are many inexpensive and effective

interventions for preventing unintended pregnancy; however approximately 45 million pregnancies per year end up in abortion, and an estimated 20 million of these are conducted in unsafe environments or performed by unskilled individuals, putting more women at risk every year (Glasier et al., 2006). There is a growing realization that abortion is a social reality which is often practiced despite legal

restrictions, and is an integral part of women's sexual and reproductive health rights (Glasier et al., 2006; Singh et al. 2009). In Africa, an estimated 92% of women of childbearing age live in a country with restrictive abortion laws (Singh et al., 2009). Studies suggest that legal access to abortion services improves sexual and reproductive health (Grimes et al., 2006). Ensuring access to safe abortion could reduce unintended pregnancies, births, maternal ill-health and mortality as well as reduce HIV infections in infants (Orner et al., 2010).

Abortion was legalized in South Africa with the Choice on Termination of Pregnancy Act in 1996 (Mhlanga, 2003). This Act gives women the right to request termination of pregnancy (TOP) up to and including the 12th week of pregnancy and under certain circumstances between the 13th and 20th week of pregnancy, to be provided by a certified nurse practitioner or medical doctor (Mhlanga, 2003). In 2004, an amendment was added in order to make termination of pregnancy services more available for women. This amendment allows for any health facility that has a 24-hour maternity service to offer first trimester abortion services (Hoffman et al., 2006). It also allows registered nurses that have completed a TOP training course to provide first trimester terminations, expanding the base of providers for abortions. As a result of this legislation studies suggest that there has been a reduction in maternal deaths from unsafe abortions, although they are still occurring (Mhlanga, 2003; Jewkes et al., 2005). Despite the encouraging statistics on decreased mortality and morbidity rates for abortion related complications, the number of legal abortions performed each year make up only a small number of abortions done in South Africa (Knudson, 2006). Studies have found that even after the legalization of abortion, many women were still aborting outside of health facilities in South Africa (Jewkes et al., 2005).

The continuing high rate of unsafe abortions is due to a variety of interconnected factors. Women may lack awareness of the availability of safe abortion services. A study done in the Western Cape found that 32% of women did not know that abortion is legal (Morroni et al., 2006). Another study found that 54% of women presenting at a hospital for incomplete abortions had not used legal services because they did not know about the law (Jewkes et al., 2005). Not only are women unaware of the abortion legislation, a study done in KwaZulu Natal found that 68% of participants were not aware of any existing facility for TOP (Moodley &

Akinsooto, 2003). In addition, there is often confusion over the fee status of abortion in South Africa as most women are unaware that the service is provided for free in public facilities. (Varga, 2002) While abortion services are provided for free, poverty still limits access to health services and family planning (Knudsen, 2006). In addition, the provision of abortion services around the country has been severely curtailed by the general lack of abortion facilities and shortages of trained health care providers (Cooper et al., 2005). A lack of confidentiality is another barrier (Jewkes et al., 2005). The lack of privacy and health providers' negative attitudes have been cited in numerous studies as a deterrent for using public, safe abortion services (Knudsen, 2006; Morroni et al., 2006; Varga, 2002). Most health workers supported abortion in the case of rape or incest, or if it would endanger a woman's health, but few supported it for social or economic reasons. (Harrison et al., 2000; Harries et al., 2009). Providers may also assert conscientious objection and ignore the legal obligation to refer women to other facilities, creating a barrier to care (Cooper et al., 2004). This leads women with no other option but to either patronize unqualified practitioners or resort to self-induced abortion (Jewkes et al., 2005).

Despite the health implications and risks associated with abortion particularly when it is not carried out by a certified professional, methods for abortion have received less priority and have not been fully addressed. In the 1980s, medical abortion was developed as an alternative to surgical abortion, which is essentially a combination of two drugs that induce a miscarriage. Advocates suggest that medical abortion has the potential to reach more women, particularly in developing countries, where approximately 97% of deaths from unsafe abortion take place, because no surgical procedures are required (Sedgh et al., 2007). In 2001, the Medicines Control Council (MCC) of South Africa approved the use of mifepristone in conjunction with misoprostol for termination of early pregnancy up to 56 days from the last menstrual period (LMP) (8 weeks) (NAF, 2009). To our knowledge, there is no formal national policy that allows for the provision of medical abortion in public health facilities. Research is ongoing assessing the feasibility of integrating medical abortion into public health services.

The main aim of this study was to explore the influences on young women's decision-making, specifically with regard to abortion in Durban, South Africa. It focuses on awareness of medical abortion and whether or not women find it to be an acceptable method for termination of pregnancy. In addition, it investigates the barriers that women face accessing abortion services. The study draws on interviews with university students in Durban, South Africa. Students, of course, are far from typical of young people but they are of special importance because they are often agents of social change, and can serve as an indicator as to whether or not there will be a demand for medical abortion. In South Africa fertility levels have declined but unwanted pregnancies among young women remains high. Among young women less than 30 years of age approximately 55% reported unintended pregnancies (SADHS, 2003). Focusing on this age group is critical in order to tailor effective interventions to prevent the occurrence of unsafe abortions and ensure that services are provided for the population that is most at risk.

Methodology

The study was conducted at a university in Durban, South Africa. Durban is located in the province of KwaZulu-Natal. The study site was selected because over the past ten years KwaZulu-Natal has one of the highest rates of termination of pregnancy and lowest rate of functioning abortion facilities (Health Systems Trust, 2009). The province also has the highest HIV prevalence in the country, at almost 37% and is confronting major sexual and reproductive health problems (Department of Health, 2012.).

The study draws on in-depth, open-ended interviews conducted among female university students aged less than 30 years. In Africa, in particular, almost 80% of unsafe abortions are happening among women under 30 (Shah and Ahman, 2004). In addition, studies have found that for developing regions as a whole unsafe abortions peak among women aged 20-29 years old (Grimes et al., 2006; Shah and Ahman, 2004). Twenty interviews were conducted with female students under the age of 30 over a three-month period from October to December 2009. Due to the sensitivity of studying abortion, qualitative methods were deemed most appropriate in order to discover the complex factors that influence perspectives on and experiences with abortion. The interviews were

open-ended to allow respondents to share their personal experiences. Interviews began by assessing the demographic profile and reproductive history of each participant. Questions covered topics such as: partner history; contraceptive use; pregnancy history; religious beliefs; knowledge of abortion legislation; and abortion methods.

Respondents were recruited through chain referral sampling through various sources including: student associations, email list servers and referrals. All the respondents were informed about the purpose of the study and asked if they would be willing to participate in the study. Informed consent was obtained before each interview. Interviews were conducted onsite at the university, and lasted on average about one hour. Interviews were conducted in English by the principal investigator. English was used because it is the main medium of instruction at the university. All interviews were digitally recorded with consent from each participant. All respondents were assured of anonymity, and confidentiality was maintained at all times. Ethical approval was obtained from the Ethics Committee at the Faculty of Humanities, Development, and Social Sciences at the University of KwaZulu-Natal before the commencement of the study. All participation was voluntary and respondents were free to withdraw at any time after having signed the informed consent sheet.

The digital recordings were transcribed and key concepts and themes were identified to create a coding framework to base the analysis and organize the data. The data was drawn, coded into analytic themes, and then translated into designated themes and synthesized to carry out a thematic analysis using Nvivo.

Results

Background information of the respondents

The ages of the women interviewed ranged from 21 to 28 years. The mean age of the sample was 23 years. In the sample, 11 women were black African, 6 white, and 3 Indian. The students included both undergraduates and postgraduates. Just under half of the women claimed religious affiliation- the majority being Christian. Over half of the women had a regular partner. However, only one of the women reported that she was married. In the total sample, three stated that they had children, while one woman reported having experienced a miscarriage. There was only one woman who reported two

previous abortions. All of the women who had previous pregnancies reported that they were unplanned and unexpected.

Awareness and attitudes towards abortion

The majority of women (90%) were aware that abortion is legal in South Africa, however they had inadequate knowledge of the legislation. In addition, they reported that they did not know where to access services, the cost of services and whether or not TOP services are available at public facilities. A few women (2) were unaware of the legality of abortion in South Africa, of which one of them had an abortion outside of a health facility through an illegal provider.

Overall, a substantial number of the respondents expressed negative attitudes to abortion and claimed that they would not have an abortion if they were to become pregnant. However, a few of the women (5) reported they would have an abortion if they became unexpectedly pregnant. While on the one hand the women were against abortion, there was an ambivalent attitude when imagining different circumstances in which one becomes unexpectedly pregnant. The respondents said that under certain circumstances, namely rape or dangerous medical conditions, they would consider terminating the pregnancy.

“Although I am against abortion in principle, there are circumstances, look even if abortion is not legalized; people are still going to do it. And then it raises the question should you rather have it where they can do it in a safe environment? Or do it in the toilets where they are at risk as well.” (P20)

The reports from this study suggest there is a gap between ideals and real life practices in relation to abortion. On the one hand women say they are against abortion; but on the other hand, when an unexpected pregnancy occurs, the reality might be different.

Reasons Why Women Induce Abortion

The most common reason reported for seeking abortion services was in the case of being a victim of rape. If a pregnancy resulted from such an act of violence, the majority of women would have an abortion, and would be supportive of other women making the same decision. Many women mentioned that rape is a serious problem in South Africa.

“If I got raped, I would not want that baby because I know it is not it’s [the baby’s] fault, but it is the product of hate.” (P3)

“If you think of women that are raped...what could they do? It [abortion services] was not available, and that is why they resort to illegal abortions in some cases.” (P11)

Women expressed a desire to finish their studies and establish a career before commencing childbearing. Many women’s aspirations for the future were dependent on finishing their university degree, and having a child was seen as a barrier to this success.

“...I was a student, so I knew that if I do not have the abortion then it will be over for me...so I had to do the abortion, even though I did not like it. For me, I had no choice.” (P8)

Without resources to support a child, many women said they would most likely resort to having an abortion. Two women, who already have a child, said they were not in a financial position to support an additional child. Women commented that many families in South Africa struggle on a daily basis to survive and maintain the basic necessities for their children.

“If it [abortion] is not available then it increases people...children coming to this world in poverty and unemployment. (P17)

Women who were experiencing problems in their relationship would consider terminating the pregnancy. Some women said that if their partner was not supportive of the pregnancy, they would rather choose to terminate than go ahead with the pregnancy.

“I had this boyfriend, so I did not use the condom. So I got pregnant, and then we were no longer in love; so I thought I cannot have the baby for him, if we were not in love. So I did not want to have another baby [and had an abortion].” (P8)

Women reported having friends who had abortions because their partners either physically or emotionally abused them. In addition, if they found themselves in situations where their partner is

abusing them, they would not want to risk the health of a child as well. In the case of dangerous medical conditions that posed a risk for the mother or the child; some women felt that the risk of a child being born with birth defects or another serious disability was an acceptable reason for opting for an abortion.

Reasons for Opposing Abortion

As stated earlier, the majority of women were generally opposed to abortion. Many regard abortion as “murder” and are “morally opposed” to it. Religious affiliations were reported to greatly affect women’s reproductive decision-making.

“It is religious beliefs themselves, and just moral, killing someone, a human being; you are killing a human being.” (P14)

“Under the circumstances I was scared to do an abortion. I am always scared because of many things, religion and everything, and you are thinking to kill this thing that is your baby. So I decided to keep it and something happened [a miscarriage].” (P19)

For some, abortion is equivalent to murder. Their families and the churches they attend influenced many of these women’s beliefs. Some women attended religious schools, which influenced their attitudes toward abortion.

“I went to a Catholic school that was very anti-abortion actually. They would show you a picture of a baby at one week, or a fetus...I think we learnt abortion was evil, number one.” (P10)

Women said they would not have an abortion because of the attitudes of their male partner. Men were perceived as holding negative attitudes toward abortion.

“The thing that prevented me from doing that thing [abortion] was my boyfriend suspected that I was pregnant. So he prevented everything because I could not go on...with the abortion because he knew that I was pregnant.” (P8)

“Some [men] ask a woman to keep the baby; even though they know themselves that they won’t support that baby. They run away, and women will be left alone to raise the child.” (P19)

It is not uncommon for women to report that their family was opposed to abortion. One woman said when she became pregnant for the first time her family persuaded her to not have an abortion when she wanted to have one.

Barriers to Abortion Services

The women admit that abortion is something that is not often talked about in communities, within families, or even among friends. They reported that abortion was socially unacceptable. A few women said that there are serious social consequences for having an abortion because of the stigma attached to the act, women face being outcast from their communities. Due to the stigma, women do not discuss abortion and seek alternative methods, which perpetuates the cycle of unsafe and illegal methods. Cultural beliefs against abortion also deter women from using health facilities for abortion services.

“I think that there are a lot of cultural complications. Abortion in general being socially taboo...I know that traditional healers have some sort of plant that you can take that terminates pregnancy.” (P16)

“I think that they [cultures] limit women...from going to the hospitals, because there is always those ways that they say to abort...you know different cultures have different ways, methods that they think you can use to abort.” (P13)

According to the black respondents that were interviewed, Zulu culture does not accept abortion, which deters women from seeking safe services. They mentioned the annual reed dance, or virginity testing, that is still practiced in some areas idolizing women’s chastity and purity.

“And there is the whole reed ceremony thing, they go for virginity testing and what not. And if you are having sex you are going to be isolated from the whole community, so you are going to keep quiet. And if you are pregnant also, everyone would know...But there are these crazy things, because they [communities] scare them [women] from going to hospitals or clinics.” (P19)

The women also made reference to the attitudes of health care workers as a major deterrent in

seeking abortion services because of the negative judgment and disapproval from staff at clinics and hospitals.

“They [nurses] are so hostile down there [clinics]. They would not allow a young person to come for contraceptives, even for your condoms. They will be asking what, you are having sex at this age?” (P19)

“Some nurses are judgmental, you know that? I know because I know so many people who have done abortion...It is the belief that abortion is murder.” (P7)

Women say that nurses and other health care workers are deeply judgmental and often impose their own views of abortion on to their patients, which makes women uncomfortable. Women then seek providers outside health facilities that will be less judgmental. In addition, the perception that public medical facilities do not provide quality care was cited as a reason why women would seek care in either the private sector or services from illegal providers.

“I do not trust the public system. And I would rather go to a private doctor...There are too many patients. There is an insufficient amount of doctors. I think the standard of care is substandard.” (P20)

It was also mentioned that hospitals take a limited amount of patients per day, making it very difficult for the majority of women to access abortion services. The following is one woman's description of her experience of the abortion services in a public hospital in Durban:

“And the first time I went there [abortion clinic] they take 10 people a day, so you have to wake up early in the morning, maybe about five o'clock you have to be there. And it was not easy, waking up at that time...I go there, and then I come back, it was so full. They have their 10 people, so I have to come back...I slept on the hospital bench, so that I could wait there, wake up early, instead of going home...You sign some papers about doing the abortion, and then they do not give you the pills that day, you have to come another day to take the pills and then come back another day for cleaning.” (P8)

Women are often forced to travel long distances to reach hospitals where abortion services are available, and because of the limited number of patients taken per day they are often unable to access these services.

Women who fall unexpectedly pregnant and are unaware of the abortion legislation, specifically the fact that abortion services are free in public hospitals, or face barriers in accessing abortion services often turn to methods outside of health facilities.

“Especially for the teenagers who do not have money...Private consultations fees are so high. Because most of the people who are falling pregnant now are teenagers, those ones who are at school, that is why they prefer to do the other route, the R300 written all over town.” (P19)

Many women voiced concerns about the abortion advertisements that are posted throughout the city of Durban promoting “safe abortion” services for women. They felt that many of these private providers are exploiting women in vulnerable situations.

“...I think the people that are involved are making good bucks [money] out of women in troublesome situations, they are trying to capitalize on it...they [women] have no options.” (P11)

The following is a description of a woman's personal experience with having an abortion outside of a health facility after she was turned away at the hospital for being too far along in her pregnancy at 13 weeks:

“It was this old lady, like when we were there in the hospital, maybe a lot of girls talk, ‘so and so is doing an abortion’, and so you take numbers and so I go to that [place]...it is an old lady. She is the one that inserts the pills in me, and then you go, and that is it for her...for me it did not take too long, maybe it was like five hours...After the baby comes out, you are just thinking and bleeding.” (P8)

Women reported a variety of unsafe methods that are often used for induced abortion such as: pills (oral and vaginal insertions); coat hangers; drinking sodas, laxatives and detergents; and

traditional methods, *umuthi*. These methods may sometimes lead to life-threatening complications but women prefer to take the risk instead of using public facilities.

“She told me they put the pills there [in her vagina], and told her to go home, and then eventually that [the fetus] will come out, eventually dead. And she almost died. And we wanted to take her to the hospital, and she refused, she was like, no...I would rather die here, I am not going to hospital.” (P19)

Medical Abortion

In the interviews women highlighted that in addition to the barriers that deter women from seeking safe abortion services, they seek alternative unsafe methods perhaps because of a lack of options of methods to choose from. So the interviews then explored attitudes toward different abortion methods and investigated awareness and acceptability of medical abortion among this sample of women. The findings suggest that acceptability of medical abortion was high among participants. Almost 30% of participants had some knowledge of medical abortion as a method, but those that had heard of it before had limited knowledge.

All of the women in this study discussed the unsafe abortions happening around South Africa, and some women thought that medical abortion had the potential to reduce the prevalence of these unsafe methods. Some women mentioned that medical abortion provides an alternative to surgical abortion, which would improve the sexual and reproductive health of women by allowing them to make a choice based on their preferences and individual contexts.

“It [medical abortion] needs to be available, again you cannot say there is one right way to have an abortion.” (P16)

“I think it should [be made available] because there are different women with different backgrounds, if this could help women, like those people that are doing abortion, unsafe abortion, I think it could work...” (P14)

The majority (65%) of women would choose medical abortion as a method if it were available, accessible, and affordable. Reasons women preferred medical abortion fell into several broad

categories. The most common advantage mentioned was privacy associated with medical abortion.

“...you can do it [medical abortion] without many people knowing, without having the stress of going in to be almost operated on.” (P20)

“...medical abortion- the advantage is you can do it on your own. You get the pill and you just take it.” (P4)

Women would prefer an abortion method that can be done discretely without revealing their actions to people in their community. It can be done at home versus a clinic, which reinforces the privacy aspect of the method. Avoiding surgery was another advantage mentioned by multiple women. Some women felt that medical abortion was a method that appeared “easier” and “simpler” than surgical abortion.

“I just think it seems easier to do a medical abortion. It is a lot easier to get a pill than to find a surgical procedure.” (P6)

“Also I do feel that is easier, and it feels more like a miscarriage. So I think you think to yourself well it is more acceptable doing it this way.” (P20)

A few women said medical abortion would be easier psychologically, one can think of it as a miscarriage, as it is more similar to a woman’s menstrual cycle. Some women also felt they would have a greater sense of control with medical abortion as opposed to surgical abortion. In addition some women mentioned that psychologically it would be easier to terminate earlier in gestation because the fetus seems less lifelike.

Although there were many women with favorable attitudes and who accepted medical abortion, there were also concerns and reservations about the method. The most common concern was the fear of adverse side effects and complications. There was a worry expressed by some women that they would not be able to reach health services either because they did not want to disclose what they were doing to others, or because they were unable to readily access health facilities. They were afraid of what would happen if there were

complications and they did not know how to handle them.

A lack of financial resources was another barrier reported to accessing medical abortion.

Young women who fall pregnant are most often not financially independent. Further those women who are falling unexpectedly pregnant and are unaware of the abortion legislation, specifically the fact that abortion services are free in public hospitals, often turn to methods outside of health facilities.

Some women felt that follow-up visits would not always be carried out, and therefore the method would not be effective, and as a result, unsuitable for women in South Africa. In addition, systemic concerns about the health system and transport system were raised. The public transport system makes it difficult in some areas to reach a hospital or clinic easily.

“But you know, the problem with public hospitals is that people never do follow-ups I think I would be a bit skeptical. Because people might not do the follow-up or finish their medications, and that would cause problems because I do not think our clinics or our health care can actually have the capacity to deal with what is going out, giving pills and making sure that people take them and come back and what not.” (P2)

A few women raised concerns that medical abortion would end up being “too accessible” to women and abortion would be made “too easy”. The majority of women were against abortion, except under certain circumstances, so a few of these women mentioned that if abortion methods were made too available to women, some would take advantage of this method and neglect other measures of preventing pregnancy. There is the concern that medical abortion would be used as a contraceptive method to prevent an unplanned pregnancy. There were also concerns about the regulation of the medication among providers. There was a fear that it could be taken outside of health facilities and contribute to the reported existing market of illegal abortion providers.

However, there was a general consensus that choices such as medical abortion should be available, accessible, and affordable for women in South Africa.

Discussion

There is no proclaimed “best method” for termination of pregnancy; it is highly dependent on individuals and various local, regional, national, and international contexts. Termination of pregnancy services should take into account why women have abortions, the context in which these decisions are being made, and women’s preferences. Unlike surgical abortion, midlevel providers, which include nurses, physician assistants, family planning workers, and midwives, can be trained to provide early medical abortion services (Berer, 2009). It could also contribute to fulfilling women’s sexual and reproductive health rights, providing more choices to best suit their needs. Generalizing the findings of this study must be done cautiously as the results are not applicable to the general population because it is based on a small sample of young women. In addition, it was based on a sample of women willing to talk about abortion and their experiences, which limits the study to particular social networks. In addition, while the university setting holds a diverse population, it lacks the opinions of women from a broader range of backgrounds. Despite these limitations the study does give important insights into the perspectives of young women with regard to termination of pregnancy.

The findings reveal that decisions around termination of pregnancy are complex and involve a variety of factors. The majority of women recognize that it is a context-driven choice and it is likely that they would have to make a decision when confronted with an unintended pregnancy. Consistent with other findings, women often have ambivalent attitudes toward abortion (Hessini, 2005; Patel & Myeni, 2008). While the majority of women say that they are against abortion, there are certain circumstances in which abortion is justifiable. Understanding the complex nature of these decisions makes it impossible to predict women’s behaviors when faced with an unintended pregnancy. Therefore measures should be taken to ensure that all options are available to suit women’s needs during these difficult moments when decisions need to be made.

In general the barriers to accessing abortion noted in this study: social stigma; finances; and negative attitudes of health professionals are consistent with findings from previous studies (Cooper et al., 2004; Hord & Wolf, 2004; Jewkes et al., 2005). These barriers often contribute to a high

prevalence of unsafe abortions. Despite the fact that it is over a decade since the legalization of termination of pregnancy in South Africa, attitudes of health providers appear to not change; women are still reporting negative attitudes and experiences at health facilities. These findings also support studies that women are still using unsafe abortion methods in South Africa (Jewkes et al., 2005). In addition, the fact that only 30.4% of abortion facilities in KwaZulu-Natal are functioning creates yet another barrier to accessing abortion services (Health Systems Trust, 2009). The reported market of abortions happening outside of health facilities advertised throughout Durban suggests that women use these services often, placing themselves at risk.

These findings of unsafe, illegal abortions highlights the need for more research to be done and measures taken to find ways to reduce the prevalence of unsafe abortions. Due to the small number of participants and the selection bias of this study it is recommended that future research look at a broader spectrum of women from varying backgrounds, locations, and ages to assess women's attitudes to abortion and barriers women face in accessing services in order to ensure that safe abortion services are acceptable, accessible, affordable, and available for all women.

Medical abortion is seen as acceptable and the preferred method of the majority of women in this study. This is consistent with findings in the literature, further enforcing the idea that medical abortion will be a positive contribution to women's sexual and reproductive health (Cooper et al., 2005; Kawonga et al., 2008). Medical abortion has the potential to not only save lives, but also to expand women's options for protecting their sexual and reproductive health. However, the women noted that it would not be a successful intervention if the cost of medication is not reduced in order to make it truly accessible to women. If more options are available to women that are suitable to their needs there is a greater possibility they would seek services at health facilities instead of outsider providers. In terms of sexual rights, abortion is a constitutional right for all women under South African law, and therefore all methods should be made available and accessible to them. The legislative framework exists to support the integration of medical abortion into the South African public health system, and it has been found

to be acceptable to women, so the time is now to introduce these services.

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Ashley Gresh contributed to the design, implementation, data analysis, and manuscript writing. Pranitha Maharaj contributed to design, implementation, and to critical manuscript comments.